PRINTED: 05/12/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E183	B. WING				C 11/2015
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER	RLTCU		PC	REET ADDRESS, CITY, STATE, ZIP CODE D BOX 129 UINTER, KS 67752	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	The following citation complaint investigation	s represent the findings of n #86480.					
F 157	provider on 5/12/15.	deficiencies was sent to the	F	157			
SS=D	(INJURY/DECLINE/R						
	or an interested family accident involving the injury and has the pot intervention; a signific physical, mental, or p	ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician tentiant change in the resident's sychosocial status (i.e., a mental, or psychosocial					
	status in either life thr clinical complications significantly (i.e., a ne existing form of treath consequences, or to o	eatening conditions or); a need to alter treatment eed to discontinue an nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the res or interested family m change in room or roo specified in §483.15(resident rights under	promptly notify the resident ident's legal representative ember when there is a symmate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of					
		rd and periodically update ne number of the resident's					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: H032101

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E183	B. WING _			C 05/11/2015
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTE	R LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	!	00/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	Continued From pag	e 1 or interested family member.	F 1	57		
	by: The facility had a ce sample included 3 re for resident neglect. I record review and int notify the physician of medication, ordered administered to 1 same findings Included: Resident #1's annuassessment, dated 0 resident had short ar problems and severe physical and verbal be indicated the resident without an assistive of	for behaviors, not mpled resident. (#1) ual (MDS) Minimum Data Set 2/18/15, indicated the nd long term memory ely impaired cognition with behaviors. The MDS also t walked independently device and displayed , placing the resident at				
	behaviors indicated t standing mental heal and wandered and/o The CAA for behavio	Care Area Assessment for he resident had long th problems with behaviors repaced almost constantly. rs also indicated the resident as combative towards staff.				
	wandered and attem almost constantly. The closely supervise the redirect as needed, a	an indicated the resident pted to leave the facility ne care plan directed staff to resident as possible, and be aware of the e/combative behaviors. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183	B. WING		C 05/11/2015
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	03/11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 157	simplify tasks to avoid further directed staff the resident when he reapproach in a calm. The 03/30/15 physic the resident had progressive mental failing memory, confunderstandable specified the resident had war behaviors with increasion combativeness towal indicated the physici Risperdal (antipsych milligrams (mg) ever medication decreased. The 03/31/15 at 3:08 the resident's family and told staff not to a medication to the resident's physicic complete a yearly (For the resident and a resident's status since medication the resident to the resident's status since medication the resident and a resident's status since medication the resident and a resident's status since medication the resident to the physician treceived the anti-	ed staff to avoid Intain a calm environment and id agitation. The care plan to keep a safe distance from elshe was aggressive, and in manner. It ian office visit note indicated gressing dementia disorder characterized by usion) with less ech and intellectual function. It is the facility's staff reported indering and/or elopement asing agitation and rds staff. The note further an ordered a trial dose of otic medication) 0.25 by night, to see if the ed the resident's behaviors. Is AM, nurse's note indicated member called the facility administer the Risperdal sident until the family elephysician. It ian order directed staff to is SBS) finger stick blood sugar asked staff to report the ce initiating the antipsychotic int's medical record revealed ele staff reported the resident had psychotic medication as ician 11 days ago, to reduce	F 15	7	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		17E183	B. WING			C
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752		05/11/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	Continued From pag	ge 3	F 15	57		
	staff notified the phy unwilling to allow the medication to help w with the physician. (ordered the Risperd Review of the March Medication Administ held the resident's F	n and April 2015 (MAR) tration Record revealed staff Risperdal 0.25 mg for tia with behaviors, from				
	resident ambulated door and activated t Continued observati	PM, observation revealed the independently to the east exit he wanderguard alarm. on revealed 2 staff rected the resident away from				
	resident had severe wandered or paced had a wanderguard staff redirected the r resident had frequer and combativeness physician ordered at the resident's behave due to family concer aware if staff notified administering the modern of the physician and the physician and the staff reported wandering and frequence wandering and frequence wandering and the physician and the staff reported wandering and the physician and the staff reported wandering and frequence wandering and the staff reported wandering and the staff redirected the resident had frequency and the staff redirected th	PM, Nurse C stated the ly impaired cognition, throughout the facility and alarm. Nurse C also stated resident constantly and the nt behaviors of resisting cares with staff. Nurse C stated the n antipsychotic medication for riors, staff held the medication rns, and this nurse was not d the physician about not redication to the resident. PM, Administrative Nurse D the resident's constant uent combative behaviors to re physician ordered an action (Risperdal) to decrease				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		475402				С	
		17E183	B. WING			05/11/2015	
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTE	R LTCU		STREET ADDRESS, CITY, STATE, ZIP COI PO BOX 129 QUINTER, KS 67752)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	held the antipsychotic concerns, and staff d physician. The facility failed to n antipsychotic medicar	ors. Nurse D stated staff comedication due to family id not immediately notify the otify the physician of antion, ordered for behaviors,	F	157			
F 225 SS=D	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowle court of law against a indicate unfitness for other facility staff to the or licensing authoritie. The facility must ensuinvolving mistreatment including injuries of unisappropriation of reimmediately to the act to other officials in act through established patterns and certain the facility must have	c)(2) - (4) DRT VIDUALS employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s. ure that all alleged violations at, neglect, or abuse, nknown source and esident property are reported eministrator of the facility and cordance with State law procedures (including to the iffication agency). e evidence that all alleged why investigated, and must tial abuse while the	F	225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		17E183	B. WING		C 05/11/2015	
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	09/11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 225	to the administrator of representative and to with State law (include certification agency) incident, and if the a	estigations must be reported	F 22	25		
	by: The facility had a ce which 3 residents we risk. Based on obser interview the facility and unwitnessed fall	T is not met as evidenced ensus of 33 residents, of ere reviewed for elopement evation, record review, and failed to report an elopement to the State survey and within 24 hours for 1 of 3				
	indicated Resident # 04/15/15 at 05:15 Pt hallway. The nurse's assessed the resident the resident to the enand treatment. Review of the state a Investigation Report indicated the facility	nt's head abrasion and sent mergency room for evaluation agency's Complaint/Incident for Complaint #86480 reported the elopement and cy on 04/28/15 (13 days after				
	stated he/she was o	PM, Administrative Staff E n leave at the time of the d the elopement to the state				

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		17E183	B. WING			C 05/11/2015	
	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER	R LTCU	1	F	TREET ADDRESS, CITY, STATE, ZIP CODE TO BOX 129 QUINTER, KS 67752	1 00	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Administrative Staff E system in place for of to the state agency. On 05/06/15 at 3:52 F stated the facility sho to report incidents to hours as directed by a stated the facility's 12/02/05 directed the risk manaincidents to the approximation of the facility failed to result of the certification agency with 483.25 PROVIDE CAHIGHEST WELL BEIL Each resident must reprovide the necessary or maintain the higher mental, and psychosological.	re/she returned to work. It stated the facility had no sher staff to report incidents PM, Administrative Nurse D wild have a system in place the state agency within 24 the facility's policy. Pabuse and neglect policy ager to report alleged opriate state agency within Peport an elopement and the State survey and within 24 hours. RE/SERVICES FOR NG Receive and the facility must by care and services to attain st practicable physical,		309			
	by: The facility had a cer sample included 3 res for resident neglect. E record review and inte provide medication for	is not met as evidenced assus of 33 residents. The sidents, who were reviewed Based on observation, erview, the facility failed to behaviors as ordered by curately monitor behaviors					

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C 17E183 B. WING 05/11/20	
	12045
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	72015
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE
F 309 Continued From page 7 for 1 sampled resident. (#1) Findings Included: - Resident #1's annual (MDS) Minimum Data Set assessment, dated 02/18/15, indicated the resident had short and long term memory problems and severely impaired cognition with physical and verbal behaviors. The MDS also indicated the resident walked independently without an assistive device and displayed wandering behaviors, placing the resident at significant risk of getting to a potentially dangerous place. The 02/18/15 (CAA) Care Area Assessment for behaviors indicated the resident had long standing mental health problems with behaviors and wandered and/or paced almost constantly. The CAA for behaviors also indicated the resident resisted cares and was combative towards staff. The 02/25/15 care plan indicated the resident wandered and attempted to leave the facility almost constantly. The care plan directed staff to closely supervise the resident as possible, redirect as needed, and be aware of the resident's aggressive/combative behaviors. The care plan also directed staff to avoid overstimulation, maintain a calm environment and simplify tasks to avoid agitation. The care plan further directed staff to keep a safe distance from the resident, when he/she was aggressive and reapproach in a calm manner. The 03/30/15 physician office visit note indicated the resident had progressing dementia (progressive mental disorder characterized by failing memory, confusion) with less	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURV COMPLETE	
	17E183	B. WING			015
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 129 QUINTER, KS 67752	05/11/2015	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COM	(X5) MPLETION DATE
understandable spece. The note also indicated the resident had war behaviors with increace combativeness towal indicated the physici. Risperdal (antipsych milligrams (mg) ever medication decrease. The 03/31/15 at 3:08 the resident's family and told staff not to a medication to the resimember spoke to the The 04/09/15 physic complete a yearly (For the resident and resident's status since medication therapy. Review of the resident and resident's status since medication therapy. Review of the physician to received the antiordered by the physician of received the antiordered by the physician of the physician of the physician of the physician to help with the physician (1) ordered the Risperdal Review of the Marchen Rev	ech and intellectual function. Ited the facility's staff reported indering and/or elopement asing agitation and inderest at trial dose of otic medication) 0.25 by night, to see if the edithe resident's behaviors. B AM, nurse's note indicated member called the facility administer the Risperdal sident until the family exphysician. Itan order directed staff to SBS) finger stick blood sugar asked staff to report the ce initiating the antipsychotic int's medical record revealed extension as in and/or the resident had psychotic medication as in an interest in a sident to start on on the family expension in the physician and April 2015 (MAR)	F 30			
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENC REGULATORY OR SUPPLIER OR SUMMARY S (EACH DEFICIENC REGULATORY OR OR SUPPLIER OR SUMMARY S (EACH DEFICIENC REGULATORY OR	TIDENTIFICATION NUMBER: 17E183 ROVIDER OR SUPPLIER UNTY MEDICAL CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 understandable speech and intellectual function. The note also indicated the facility's staff reported the resident had wandering and/or elopement behaviors with increasing agitation and combativeness towards staff. The note further indicated the physician ordered a trial dose of Risperdal (antipsychotic medication) 0.25 milligrams (mg) every night, to see if the medication decreased the resident's behaviors. The 03/31/15 at 3:08 AM, nurse's note indicated the resident's family member called the facility and told staff not to administer the Risperdal medication to the resident until the family member spoke to the physician. The 04/09/15 physician order directed staff to complete a yearly (FSBS) finger stick blood sugar for the resident and asked staff to report the resident's status since initiating the antipsychotic	TOURISH OF THE PROPERTY OF THE	ROVIDER OR SUPPLIER UNTY MEDICAL CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPCISION MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 understandable speech and intellectual function. The note also indicated the facility's staff reported the resident's admit psychotic medication to the resident's behaviors. The 03/11/15 at 3:08 AM, nurse's note indicated the resident's rainly member spoke to the physician and sked staff to report the resident's reported the resident's family member sole to the resident's reported the resident's family member sole to the resident's physician order directed staff to complete a yearly (FSBS) finger stick blood sugar for the resident and saked staff to report the resident's status since initiating the antipsychotic medication as ordered by the physician and to received the antipsychotic medication as ordered by the physician and to received the antipsychotic medication as ordered by the physician and to the resident's medication as ordered by the physician regarding the family unwilling to allow the resident to start on medication to help with behaviors until they visit with the physician (16 days after the physician ordered revealed staff notified the physician (16 days after the physician ordered report ordered the resident's behaviors. The 04/15/15 at 2:30 PM, nurse's note indicated staff notified the physician regarding the family unwilling to allow the resident to start on medication to help with behaviors until they visit with the physician (16 days after the physician ordered the Resident's state on medication to help with behaviors until they visit with the physician (16 days after the physician ordered the Risperdal) Medication Administration Record revealed staff for the March and April 2015 (MAR) Medication Administration Record revealed staff	TOTAL TOTAL STATE OF THE ADDRESS. GITY. STATE. ZIP CODE PO BOX 129. ITEMS

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED	
		17E183	B. WING _			C 05/11/2015
	ROVIDER OR SUPPLIER UNTY MEDICAL CENT	ER LTCU		STREET ADDRESS, CITY, STATE, ZIP COE PO BOX 129 QUINTER, KS 67752	DE	33,11,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	O3/30/15 to 04/15/1 The facility's March Behavior/Interventic staff to record and raggressive behavior and night). Review revealed the following the staff recorded as shifts. On 05/06/15 at 2:10 resident ambulated door and activated continued observators and activated continued observators and redicted to exit the build resident often because when staff attemptes staff should document the end of each shifts. On 05/06/15 at 3:12 resident had severe wandered or paced had a wanderguard staff redirected the resident had frequents.	tia with behaviors, from 5 (16 days). April and May 2015 on Flow Records directed the monitor the resident's rs every shift (day, evening of the behavior records ng: corded in March out of 93 ecorded in March out of 90 shifts corded in May out of 16 shifts 4 behaviors on a possible 199 DPM, observation revealed the independently to the east exit the wanderguard alarm. iton revealed 2 staff rected the resident away from TPM, Nurse Aide A stated the walked without an assistive erguard alarm and frequently ding. Nurse Aide A stated the me agitated and combative and to redirect the resident and cent the resident's behaviors at	F3	309		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E183	B. WING		C 05/11/2015
NAME OF PROVIDER OR SUPPLIER GOVE COUNTY MEDICAL CENTER LTCU			PC	PREET ADDRESS, CITY, STATE, ZIP CODE D BOX 129 UINTER, KS 67752	05/11/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 309	the resident's behave due to family conce aware if staff notifie administering the m Nurse D further stat recorded the reside On 05/06/15 at 3:29 confused resident he and/or paced constracility everyday. Note that the resident was ag staff. Nurse Aide B document the resident he resident was ag staff. Nurse Aide B document the reside each shift on the flood On 05/06/15 at 3:52 reported the resident frequent combative and the physician of medication (Rispercy behaviors. Nurse D antipsychotic medic to family concerns, physician about the his/her antipsychotic stated staff had not resident's frequent I Flow Record. The facility failed to behaviors as ordered.	in antipsychotic medication for viors, staff held the medication rns, and this nurse was not d the physician about not ledication to the resident. Ited the certified nurse aides nt's behaviors every shift. In PM, Nurse Aide B stated the lad a wanderguard, wandered antly and tried to exit the larse Aide B stated staff ent frequently and most times itated and combative towards further stated the staff should ent's behaviors at the end of	F 309		